# L&I Extract Record Layout

## Professional Services Fee Schedule TXT File

Effective: 8-1-03

| Field No. | Field Description | Field Length | Start Position | COBOL Picture |
|---|---|---|---|---|
| 01 | Effective Date (YYYYMMDD) | 8 | 1 | X(8) |
| 02 | CPT4/HCPCS/Local Procedure Code | 5 | 9 | X(5) |
| 03 | Procedure Code Modifier | 2 | 14 | X(2) |
| 04 | Procedure Code Description (UPPERCASE) | 50 | 16 | X(50) |
| 05 | Agency Procedure Code Status | 1 | 66 | X(1) |
| 06 | Source of RVUs | 1 | 67 | X(1) |
| 07 | Total Non-Facility Setting GPCI Adj. RVUs | 9 | 68 | 9(7)V99 |
| 08 | Total Facility Setting GPCI Adj. RVUs | 9 | 77 | 9(7)V99 |
| 09 | Agency Conversion Factor | 8 | 86 | 9(5)V999 |
| 10 | Non-Facility Setting Fee Schedule Max Allowance or Anesthesia Base Units | 9 | 94 | 9(7)V99 |
| 11 | Facility Setting Fee Schedule Max Allowance or Anesthesia Base Units | 9 | 103 | 9(7)V99 |
| 12 | Fee Type Indicator | 1 | 112 | X(1) |
| 13 | Global Surgery Days | 3 | 113 | X(3) |
| 14 | Preoperative Percentage (Modifier 56) | 6 | 116 | 9V9(5) |
| 15 | Intraoperative Percentage (Modifier 54) | 6 | 122 | 9V9(5) |
| 16 | Postoperative Percentage (Modifier 55) | 6 | 128 | 9V9(5) |
| 17 | Prof/Tech Component Indicator (Modifiers 26 and TC) | 1 | 134 | X(1) |
| 18 | Multiple Surgery Indicator (Modifier 51) | 1 | 135 | X(1) |
| 19 | Bilateral Surgery Indicator (Modifier 50) | 1 | 136 | X(1) |
| 20 | Assistant at Surgery Indicator (Modifiers 80, 81, and 82) | 1 | 137 | X(1) |
| 21 | Co-surgeons Indicator (Modifier 62) | 1 | 138 | X(1) |
| 22 | Team Surgeons Indicator (Modifier 66) | 1 | 139 | X(1) |
| 23 | Related Procedure Codes | 95 | 140 | X(5) -Occurs 19 times |
| 24 | Endoscopic Base Code | 5 | 235 | X(5) |
| 25 | Filler (Future Expansion) | 31 | 240 | X(31) |

Total record length is 270 bytes.

# Field Descriptions

The following field descriptions correspond to the numbered fields on the L&I Extract Record Layout.

**1. Effective Date**

This field indicates the effective date of the procedure pricing data contained in the record. The format is YYYYMMDD.

**2. CPT4/HCPCS/Local Procedure Code**

This field represents the CPT, HCPCS or Local procedure code. The CPT procedure code format consists of five numeric digits or four numeric digits followed by the letter "T." The HCPCS Level II procedure code format consists of one alphabetic character followed by four numeric digits.

**3. Procedure Code Modifier**

The format for a CPT modifier consists of two numeric digits. The HCPCS modifier format consists of two alphabetic characters or one alphabetic character and a numeric digit. The following two-character modifiers will be displayed in this field:

| | |
|---|---|
| 26 | Professional Component |
| TC | Technical Component |
| 53 | Discontinued Procedure |
| Blanks | Global Service |

**4. Procedure Code Description**

This field includes a brief description of each procedure code, as provided by the Centers for Medicare and Medicaid Services.

**5. Agency Procedure Code Status**

This field indicates the update status of the procedure code. Valid values for this field include:

| | |
|---|---|
| A | Add |
| C | Change |

**6. Source of RVUs**

This field indicates the source of the component RVUs used to calculate the total RVUs. Valid values are:

| | |
|---|---|
| A | No RVUs, because code is an anesthesia code |
| L | No RVUs; fee is derived from the Medicare Clinical Lab Fee Schedule |
| M | Medicare Physician Fee Schedule Data Base |
| N | No RVUs are available for this procedure |
| R | Interagency Reimbursement Steering Committee (will be GPCI adjusted) |
| U | Interagency Reimbursement Steering Committee (will not be GPCI adjusted) |

**7. Total Non-Facility Setting GPCI Adj. RVUs**

This field contains the total Non-Facility RVUs for the procedure.

**8. Total Facility Setting GPCI Adj. RVUs**

This field contains the total Facility RVUs for the procedure.

**9. Agency Conversion Factor**

This field contains Labor and Industries' conversion factor as of August 1, 2003.

**10. Non-Facility Setting Fee Schedule Max Allowance (or Anesthesia Base Units)**

This field contains the non-facility fee schedule maximum allowance or the anesthesia base units for the procedure code. The method used to calculate the fee schedule amount is indicated by field 12 - Fee Type Indicator. This field is filled with zeros for procedure codes with a fee type indicator of "B," "C," "N"or "X." If the procedure code has fee type indicator "O" and this field is filled with zeros, the service is paid by report when the professional services fee schedule payment method applies in the hospital outpatient setting.

**11. Facility Fee Setting Schedule Max Allowance (or Anesthesia Base Units)**

This field shows the facility fee schedule maximum allowance or the anesthesia base units for the procedure code. The method used to calculate the fee schedule amount is indicated by field 12 - Fee Type Indicator. This field is filled with zeros for procedure codes with a fee type indicator of "B," "C," "N"or "X." If the procedure code has fee type indicator "O" and this field is filled with zeros, the service is paid by report when the professional services fee schedule payment method applies in the hospital outpatient setting.

**12. Fee Type Indicator**

This field indicates the method used to calculate the fee schedule maximum allowances. Valid values are:

| | |
|---|---|
| A | Anesthesia code paid with base and time units |
| B | Bundled Code, fee schedule max allowances are zero |
| C | Contracted Service |
| D | AWP Priced Drugs and Biologicals |
| F | Flat fee |
| L | Clinical lab fee, fees based on Medicare Fee and L&I Clinical Laboratory Multiplication Factor |
| N | Fee schedule max allowances are zero; no fee or RVUs available ("By Report") |
| O | Hospital Only Code (if fields 10 and 11 are filled with zeros, service is paid by report, else paid by maximum fee) |
| R | RBRVS fees |
| X | Non-Covered code |

**13. Global Surgery Days**

This field provides the time frames that apply to a global surgery for postoperative times. Valid values are:

| | |
|---|---|
| 000 | No postoperative days apply to this procedure |
| 010 | 10-day postoperative period applies to this procedure |
| 045 | 45-day postoperative period applies to this procedure |
| 090 | 90-day postoperative period applies to this procedure |

**14. Preoperative Percentage**

This field contains the percentage (in decimal format) for the preoperative portion of the global package. For example, 10 percent will be shown as 0.1000. The total of fields 14, 15, and 16 will usually equal one. If there is any variance it will be slight and results from rounding. The preoperative portion of a surgical procedure is indicated by modifier 56 on the claim record.

**15. Intraoperative Percentage**

This field contains the percentage (in decimal format) for the intraoperative portion of the global package. For example, 63 percent will be shown as 0.6300. The total of fields 14, 15, and 16 will usually equal one. If there is any variance it will be slight and has resulted from rounding. The intraoperative portion of a surgical procedure is indicated by modifier 54 on the claim record.

**16. Postoperative Percentage**

This field contains the percentage (in decimal format) for the postoperative portion of the global package. For example, 17 percent will be shown as 0.1700. The total of fields 14, 15, and 16 will usually equal one. If there is any variance it will be slight and has resulted from rounding. The postoperative portion of a surgical procedure is indicated by modifier 55 on the claim record.

**17. Professional/Technical Component Indicator**

This field identifies procedure codes that can be split into professional and technical components. Valid values are:

0 The concept of PC/TC split does not apply to this procedure. Modifiers 26 and TC are not valid for this procedure.

1 Indicates a diagnostic procedure or radiology service that consists of a professional and a technical component. Modifiers 26 and TC are valid for this procedure.

2 Identifies a stand alone code that describes the professional component of a diagnostic test for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global procedure (i.e., the professional and the technical components). Modifiers 26 and TC are not valid for this procedure.

3 Identifies a stand alone code that describes the technical component of a diagnostic test for which there is an associated code that describes the professional component of the diagnostic test only and another associated code that describes the global procedure (i.e., the professional and the technical components). Modifiers 26 and TC are not valid for this procedure.

4 Identifies a stand alone code that describes the global procedure for a diagnostic test for which there are associated codes that describe: a) the professional component of the test only, and b) the technical component of the test only. Modifiers 26 and TC are not valid for this procedure.

5 Identifies a code that describes services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct personal supervision. Modifiers 26 and TC are not valid for this procedure.

6 Identifies clinical laboratory or other services for which separate payment for interpretations by laboratory physicians or other physicians may be made. Modifier TC is not valid for this procedure. Modifier 26 maybe valid for this procedure (modified 6-1-93).

7 Physical therapy service. Payment may not be made if the service is provided in either a hospital outpatient or inpatient setting. Modifiers 26 and TC are not valid for this procedure. (Note: on all extracts after 5/1/95, all PC/TC Modifiers of 7 are changed to 0).

8 Identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code 85060. No TC modifier billing is recognized because payment for the underlying clinical laboratory test is made to the hospital. No payment is recognized for these codes when furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

9 The concept of a professional/technical component split does not apply. Modifiers 26 and TC are not valid for this procedure.

**18. Multiple Surgery Indicator**

Indicates which payment adjustment rule for multiple procedures applies to the service. Multiple procedures are identified by modifier 51. Valid values for this field include:

0 Payment adjustment rule for multiple surgeries does not apply. Modifier 51 is not valid for this procedure.

1 Standard payment rule in effect before May 1, 1995 for multiple surgeries applies (100 percent, 50 percent, 25 percent, 25 percent, and 25 percent). If procedure is reported on the same day as another procedure that has an indicator of 1, 2, or 3, then rank the procedure by the fee schedule amount and apply the appropriate reduction as mentioned above to this code. All reported procedures subject to the multiple surgery rules beyond the five are paid by report. Modifier 51 is valid for this procedure.

2 Standard payment rule for multiple surgeries applies (100 percent, 50 percent, 50 percent, 50 percent, and 50 percent). If procedure is reported on the same day as another procedure that has an indicator of 1, 2, or 3, then rank the procedure by the fee schedule amount and apply the appropriate reduction as mentioned above to this code. All reported procedures subject to the multiple surgery rules beyond the five are paid by report. Modifier 51 is valid for this procedure.

3 Special rule for multiple endoscopic procedures applies if the service is billed with another endoscopy in the same family. The base procedure for each code with a Multiple Surgery Indicator of 3 is listed in field 25. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day. If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy. Modifier 51 may be valid for this procedure.

9 Concept does not apply. Modifier 51 is not valid for this procedure.

**19. Bilateral Surgery Indicator**

Indicates that the procedure is subject to a payment adjustment for bilateral surgery. Bilateral procedures are identified by modifier 50. Valid values for this field include:

0 Payment adjustment rule for bilateral surgery does not apply to this procedure. The bilateral adjustment is inappropriate for codes in this category because of physiology or anatomy; or the code descriptor specifically states that it is a unilateral procedure and there is a bilateral procedure code. Modifier 50 is not valid for this procedure.

1 Standard payment rule for bilateral surgery applies (150 percent). If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules. Modifier 50 is valid for this procedure.

2 Payment adjustment for bilateral procedures does not apply. The RVUs are based on a bilateral procedure because the code descriptor specifically states that the procedure is bilateral; the code descriptor states the procedure may be performed either unilaterally or bilaterally; or the procedure is usually performed as a bilateral procedure. Modifier 50 is not valid for this procedure.

3 The usual payment adjustment (150%) for bilateral procedures does not apply. There are radiology procedures which are not subject to the payment rules for bilateral surgeries. If billed with the bilateral modifier (-50), base payment on 100% for each side or organ or site of a paired physiological entity. Modifier 50 is not valid for this procedure.

9 Concept does not apply. Modifier 50 is not valid for this procedure.

**20. Assistant at Surgery Indicator**

Indicates whether or not an assistant surgeon may be paid for the procedure. Assistants at surgery are indicated by modifiers 80, 81, and 82. Valid values for this field include:

0 Assistant at surgery may not be paid for this procedure unless supporting documentation is submitted to establish medical necessity. Modifiers 80, 81 and 82 are not valid under normal situations for this service.

1 Assistant at surgery may not be paid for this procedure. Modifiers 80, 81 and 82 are not valid for this service.

2 Assistant at surgery may be paid. Modifiers 80, 81 and 82 are valid for this service.

9 Concept does not apply. Modifiers 80, 81 and 82 are not valid for this service.

**21. Co-Surgeons Indicator**

Indicates whether or not two surgeons, each in a different specialty, may be paid for the procedure. Co-surgeons are indicated by modifier 62. Valid values for this field include:

0 Co-surgeons not permitted for this procedure. Modifier 62 is not valid with this procedure.

1 Co-surgeons may be paid for this procedure; supporting documentation required to establish medical necessity of two surgeons for this procedure. Modifier 62 is not valid under normal situations for this procedure.

2 Co-surgeons may be paid for this procedure; no supporting documentation is required if two specialty requirement is met. Modifier 62 is valid with this procedure.

9 Concept does not apply. Modifier 62 is not valid with this procedure.

**22. Team Surgeons Indicator**

Indicates whether or not team surgeons may be paid for this procedure. Team surgeons are indicated on the claim by modifier 66. Valid values for this field include:

0 Team surgeons not permitted for this procedure. Modifier 66 is not valid with this procedure.

1 Team surgeons may be paid for this procedure; supporting documentation required to establish medical necessity of a team; pay by report. Modifier 66 is not valid under normal situations for this procedure.

2 Team surgeons permitted; pay by report. Modifier 66 is valid with this procedure.

9 Concept does not apply. Modifier 66 is not valid with this procedure.

**23. Related Procedure Codes**

This field is not currently in use. No data is contained in this field.

**24. Endoscopic Base Code**

This field indicates the endoscopic base procedure code to be used with each endoscopic procedure code (codes with a Multiple Surgery Indicator of 3).

**25. Filler (Future Expansion)**

This field contains filler reserved for future use. No data is contained in this field.